SECTION 2

Audiology (Hearing)

Table of Contents

1 AUDIOLOGY SERVICES

Audiology (hearing) services include preventive, screening, evaluation, diagnostic and corrective processes planned and provided by an audiologist for which a recipient is initially referred by a physician. (See 42 CFR 440.110 and Utah Administrative Code R414-59 Audiology-Hearing Services)

*

1 - 1 Credentials

An audiologist must hold a current professional license in the State of Utah, and may provide services only in that licensed specialty. An audiologist must be enrolled with the Utah Medicaid Program to receive Medicaid reimbursement for services.

Non-licensed audiologists are not eligible to become Medicaid providers. Any services provided by a non-licensed audiologist to a Medicaid-eligible recipient must be directly supervised by a licensed Medicaid provider, who is solely authorized to bill Medicaid for services rendered.

Hearing aid providers operating as medical suppliers must be licensed by the appropriate governmental authority licensing businesses in the state where the services are provided.

1 - 2 Billing

Audiology (hearing) services are billed either through the electronic data exchange or on a HCFA-1500 claim form, using the procedure codes listed in Chapter 4. For billing instructions, refer to SECTION 1 of this manual, Chapter 11, BILLING CLAIMS.

1 - 3 Client Enrolled in a Managed Care Plan

A Medicaid client enrolled in a managed care plan, such as a health maintenance organization (HMO), must receive all health care services through that plan. Refer to SECTION 1 of this manual, Chapter 5, Verifying Eligibility, for information about how to verify a client's enrollment in a plan. For more information about managed health care plans, please refer to SECTION 1,Chapter 4, Managed Care Plans. Each plan may offer more benefits and/or fewer restrictions than the Medicaid scope of benefits explained in this section of the provider manual. Each plan specifies services which are covered, those which require prior authorization, the process to request authorization and the conditions for authorization.

All questions concerning services covered by or payment from a managed care plan must be directed to the appropriate plan. Medicaid does NOT process prior authorization requests for services to be provided to a Medicaid client who is enrolled in a capitated managed care plan when the services are included in the contract with the plan. Providers requesting prior authorization for services for a client enrolled in a managed care plan will be referred to that plan.

A list of HMOs with which Medicaid has a contract to provide health care services is included as an attachment to the provider manual. Please note that Medicaid staff make every effort to provide complete and accurate information on all inquiries as to a client's enrollment in a managed care plan. Because eligibility information as to what plan the patient must use is available to providers, a "fee for service" claim will not be paid even when information is given in error by Medicaid staff.

1 - 4 Client NOT Enrolled in a Managed Care Plan (Fee-for-Service Clients)

Medicaid clients who are *not* enrolled in a managed care plan may receive services from any provider who accepts Medicaid. This provider manual explains the conditions of coverage for Medicaid fee-for-service clients.

2 COVERED SERVICES

Audiological services include preventive, screening, evaluation, diagnostic testing, hearing aid evaluation, prescription for a hearing aid, ear mold services, fitting, orientation and follow-up. A hearing aid battery provision is included in these services. Audiologic habilitation includes, but is not limited to speech, hearing, and gestural communication.

Medicaid will reimburse two primary services and one subsequent service for Medicaid recipients: a diagnostic examination, an assessment for a hearing aid(s) and, when appropriate, a hearing aid or assistive listening device. Medicaid also reimburses repairs on hearing aids.

2 - 1 Examination and Assessment

Diagnostic audiology evaluations may be performed with a written physician's order and include procedures which may be used for a hearing aid assessment and any other diagnostic tests appropriate for the specific diagnosis as ordered by the physician.

Medicaid supports the nationally recommended strategy to have all infants receive a hearing screen. Use code V5008 for a hearing screening (otoacoustic test) for infants under one year of age.

A recommendation for a hearing aid assessment, if appropriate, may subsequently be made. Initial hearing aid assessments may be performed with a written physician's referral or request. If subsequent hearing testing shows a change in the hearing thresholds or the need for a new hearing aid, then the audiologist should refer the individual for medical clearance before proceeding with the hearing aid refitting.

If the physician's examination determines there is no impairment requiring medical intervention, then a hearing aid assessment may be performed with a referral. The hearing aid assessment, to determine candidacy for amplification, must include the following: pure-tone air conduction and bone conduction thresholds; speech reception thresholds and speech discrimination scores for each ear; MCLs and UCLs, diagnosis as to the type of hearing loss for each ear (i.e. conductive, sensorineural, or mixed), and the pure-tone average loss for 500 Hz, 1000 Hz, and 2000 Hz in each ear.

2 - 2 Hearing Aids

Hearing aids require prior authorization. Prior authorization must be requested and obtained in writing. Criteria are stated in Chapter 5. The hearing aid may be provided by an audiologist or by a hearing aid provider of medical supplies. All hearing aids, monaural and binaural, are reported and reimbursed using one of two global codes. All services, including conformity evaluation and initial ear molds, are included in each rate to cover a period of 12 months. Billing codes are listed in Chapter 6, Procedure Codes.

2 - 3 Assistive Listening Device

Assistive listening devices require prior authorization. Prior authorization must be requested and obtained in writing. The hearing loss criteria are the same as that for hearing aids. This device can be provided in lieu of a hearing aid for clients who are not capable of adjusting to a hearing aid. If the client meets the hearing loss criteria, the audiologist should look at various facts including the client’s ability to care for hearing aids, whether the client will wear the hearing aid, whether the client desires a hearing aid, and what are the expected results, in order to determine whether a hearing aid or an assistive listening device would be the most appropriate item, to meet the hearing needs of the client. This does not include an fm or rf system.

3 LIMITATIONS

3 - 1 Examination and Assessments

Diagnostic audiology examinations and hearing aid assessments must be performed with a physician's order. **Exams must be documented as medically necessary in each case and will be reviewed on a post-payment basis.**

3 - 2 Hearing Aids

Medicaid requires using hearing aids that are guaranteed by the manufacturer for a period of at least one year.

The initial ear mold, fitting of the hearing aid on the recipient, and necessary follow-up procedures (i.e. conformity evaluation, counseling, adjustments, testing batteries, etc.) are part of the global rate and will not be reimbursed separately. The global rate covers a period of twelve months.

If a follow-up examination results in a recommendation for a different model of hearing aid, the original aid must be exchanged for another aid within the 60 days allowed by retailers. No rental may be charged.

The provider must accept the return of a new hearing aid within 60 days if the physician or audiologist determines that the hearing aid does not meet specifications.

Hearing aid replacement is limited to medical necessity under unusual circumstances, e.g., an accident, surgery, disease, or other distinct changes in hearing.

Durable medical equipment (DME), including hearing aids, may not be replaced more often than every five years unless prior approved. DME is expected to last for at least five years under normal use.

Services requested for patients who reside in an ICF/MR facility are the responsibility of the facility under "active treatment" regulation. Exception: This does not include the provision of the hearing aid appliance which may be billed separately to Medicaid.

The physician's statement must be retained on file by the provider of the hearing aid for a period of three years.

4 HEARING AID REPLACEMENT, REPAIRS AND RENTAL

4 - 1 Replacement

When replacing a hearing aid for a recipient, a new medical examination and referral letter is needed. A new audiology evaluation for the replacement hearing aid is also needed.

4 - 2 Repair Limitations

Hearing aid repairs and related services do not require prior authorization.

Hearing aid repairs of $15.00 or less do not need to be itemized on the claim form.

Repairs over $15.00 must be itemized. Medicaid will only reimburse the actual cost of the parts.

The time required to repair the hearing aid may be billed to Medicaid using the appropriate procedure code listed in Chapter 6, *Codes*.

Hearing aids which are returned to the manufacturer for repair do not require prior authorization. Since limited service was provided by the dealer, only the manufacturer's bill will be reimbursed to the hearing aid provider plus a fee for handling, assessing, and mailing. The manufacturer's bill must be attached to the Medicaid invoice submitted by the hearing aid provider.

*

4 - 3 Rental Limitations

If it is necessary to send a hearing aid away for repair and the recipient requires a "loaner", Medicaid will pay rental to the provider for this service not to exceed two months. Prior approval is required for hearing aid rental.

5 PRIOR AUTHORIZATION

Requests for prior authorization for hearing aids must be submitted in writing. Send requests to:

MEDICAID PRIOR AUTHORIZATION UNIT
PO BOX 143103
SALT LAKE CITY UT 84114-3103

Requests may also be faxed to (1-801) 538-6382, attention "Prior Authorizations"

5 - 1 General

Any hearing aid provided by an audiologist or by a hearing aid provider requires the following information for the prior authorization request:

1. A physician's order, to be kept in the patient's file, stating that the patient has been medically cleared for hearing aid use;

2. The results of a comprehensive audiometric exam performed by the audiologist to identify the kind of hearing loss (i.e. conductive loss, sensorineural loss, or mixed loss), speech testing to include the speech reception thresholds and speech discrimination scores, and the pure-tone average, and in cases 17 years and under, the high frequency pure-tone average.

   Note: The high frequency pure-tone average is calculated using frequencies 1000, 2000, and 4000 hertz.

   The audiologist must identify the kind of hearing loss, conductive loss, sensory-neuro loss, or mixed;

3. The provider must identify the type of hearing aid being requested, either monaural or binaural and the respective code.

4. The audiogram or form that reports the hearing evaluation test or decibel loss will include the following information for both right and left ears: Hearing thresholds at 250, 500, 1000, 2000, 4000 and 8000 Hz.

5 - 2 Criteria

1. Criteria for Medicaid clients age 20 and older .

   A. A **monaural** aid may be authorized if the hearing test shows an average hearing loss in one ear of 35 dB or greater, based on the PTA for that ear.

   B. **Binaural** hearing aids are reimbursed only under one of two circumstances:

      (1) They must be verified with an average hearing loss of 30 dBs based on the PTA for both ears; or

      (2) The recipient is blind, and a monaural hearing aid may be contraindicated.

2. Criteria for children age 20 years and under:

   A. A **monaural** aid may be authorized if the hearing test shows an average hearing loss in one ear of 30 dB or greater, based on a high frequency PTA specially calculated for frequencies 1000, 2000, and 4000 hertz.

B. **Binaural** hearing aids are reimbursed only under one of two circumstances:

(1) Must be verified with an average hearing loss of 25 dBs, based on a high frequency PTA specially calculated for frequencies 1000, 2000, and 4000 in both ears; or

(2) The recipient is blind, and a monaural hearing aid may be contraindicated.

NOTE: A binaural hearing aid is one unit for billing purposes.

3. Brain Stem testing

If a child is cannot be tested by normal audiometric means, generally an Audiological Brain Response (ABR) is administered. This test measures responses in the 2000-4000 Hertz range.

If the ABR is abnormal or no response, the results of an Otoacoustic Emissions test (New born hearing test) and a Visual Response Audiometry test (or other similar conditioned response audiometry test) will be required to confirm the results of the ABR. All tests should confirm the need for amplification.

For more information about prior authorization procedures, refer to SECTION 1 of this Provider Manual, Chapter 9, Prior Authorization Process.

5 - 3 Digital Hearing Aids

Digital hearing aids (which do not include digitally programable hearing aids) are covered for children age six and under. Written prior authorization is required. If over age six, the client may qualify for a digital hearing aid if he/she has a language age less than six years as measured by standard tests, such as Receptive One Word Picture Vocabulary Test and meets the criteria for a regular hearing aid. For binaural digital applications, use two units of the monaural digital code.

6 PROCEDURE CODES

The table which follows describes audiology services covered by Medicaid and conditions of coverage. The list is updated by Medicaid Information Bulletins until republished in its entirety. An explanation of individual items on the tables is as follows:

Code The code is the Health Common Procedure Code System (HCPCS) used by Medicaid to identify the item or the "Y" code assigned by Medicaid. The procedure codes listed are the only ones accepted by Medicaid.

P A "P A" is written prior authorization required by Medicaid BEFORE services are rendered. If prior authorization is required for a procedure, it will say "Yes" in the "P A" column. If the column is blank, prior authorization is not required. Prior authorization must be requested and obtained in writing.

Please refer to SECTION 1, GENERAL INFORMATION, Chapter 9, Prior Authorization Process, for Medicaid policy and procedures regarding prior authorization.

Send written requests to:

MEDICAID PRIOR AUTHORIZATION
BOX 143103
SALT LAKE CITY UT 84114-3103

or use FAX NUMBER: (801) 538-6382

Criteria The criteria listed are required by Medicaid and are used by Medicaid staff to review a request for prior authorization.

Limits Indicates the allowable number of times the item may be reimbursed and other pertinent information

Coding Notes

Codes newly added to the list are in bold print.
An asterisk (*) marks where a code is newly removed.
A vertical line in the margin indicates where text or a descriptor changed for an existing code.

AUDIOLOGY CODES

CODE	DESCRIPTION	P A	CRITERIA and COMMENTS	LIMITS
V5008	Hearing screening (infant) otoacoustic test		Limited to infants under the age of one year and in accordance with the nationally recommended strategy to have all infants receive a hearing screen.	Do NOT use 92585 to bill for children under the age of one year.
V5010	Hearing aid assessment		Hearing aid (audiology) assessment includes, but is not limited to basic audiometry: ■ pure tone airbone conduction threshold test of each ear ■ speech tests including speech reception threshold SRT and speech recognition scores; ■ speech aided and unaided recognition values ■ MCL and UCL testing. Bill as one test. No identification of specific modalities is necessary.	V5010 can only be billed one per day. This is a global fee including multiple assessment for the same date of service. Multiple billings for this code for the same date of service will be denied. Code V5010 is limited to one line item and one unit of service per day on the HCFA 1500 form.
92557	Comprehensive audiometry threshold evaluation and speech recognition.		Requires a physician's order	
V5130	Hearing Aid Binaural, ITE, Global charge	Yes	Same as V5248	Same as V5248
V5140	Hearing Aid Binaural, BTE, Global charge	Yes	Same as V5248	Same as V5248
V5242	Hearing aid, analog, monaural, CIC, Global charge	Yes	1. **For clients 18 years and older:** Average hearing loss in one ear of 35 dB or greater, based on the PTA for that ear 2. **For clients 17 years and younger:** Average hearing loss in one ear of 30 dB or greater, based on a high frequency PTA specially calculated for frequencies 1000, 2000, 4000 hertz. NOTE: Two monaural hearing aids cannot be dispensed as an alternative to one binaural. Bill a monaural aid as quantity one only.	Code includes conformity evaluation and ear molds. Hearing aids must be guaranteed by the manufacturer for a period of at least one year.
V5243	Hearing aid, analog, monaural, ITC, Global charge	Yes	Same criteria as for V5242.	Same as for V5242.

CODE	DESCRIPTION	P A	CRITERIA and COMMENTS	LIMITS
V5248	Hearing aid, analog, binaural, CIC	Yes	1. **For clients 18 years and older:** Average hearing loss in one ear of 35 dB or greater, based on the PTA for that ear 2. **For clients 17 years and younger:** Average hearing loss in one ear of 30 dB or greater, based on a high frequency PTA specially calculated for frequencies 1000, 2000, 4000 hertz. Bill a binaural aid as quantity ONE only. Do not bill for quantity two; only quantity one of the binaural procedure code is available for reimbursement.	Code includes conformity evaluation and ear molds. Hearing aids must be guaranteed by the manufacturer for a period of at least one year.
V5249	Hearing aid, analog, binaural, ITC	Yes	Same as V5248	Same as V5248
V5050	Hearing Aid, monaural, ITE, Global charge	Yes	Same criteria as for V5242.	Same as for V5242.
V5254	Hearing aid, digital, monaural, CIC	Yes	1. Digital hearing aids do not include digitally programable hearing aids. 2. Covered for children age six and under who meet criteria for regular hearing aids 3. If over age six, the child may qualify for a digital hearing aid when a. He/she meets criteria for regular hearing aids and b. has a language age less than six years as measured by standard tests, such as Receptive One Word Picture Vocabulary Test. 4. Two devices may be authorized for binaural applications.	Code includes conformity evaluation and ear molds. Hearing aids must be guaranteed by the manufacturer for a period of at least one year.
V5255	Hearing aid, digital, monaural, ITC	Yes	Same as V5254	Same as V5254
V5256	Hearing aid, digital, monaural, ITE	Yes	Same as V5254	Same as V5254
V5257	Hearing aid, digital, monaural, BTE	Yes	Same as V5254	Same as V5254
V5060	Hearing Aid, monaural, BTE, Global charge	Yes	Same criteria as for V5242	Same as for V5242
V5266	Battery for use in hearing device		Specify type such as zinc air, as well as the number.	Six per month for a monaural aid. Twelve per month for binaural aids.

CODE	DESCRIPTION	P A	CRITERIA and COMMENTS	LIMITS
V5275	Ear impression, each		Hearing aids may be in-ear type, behind-the-ear type or body type; Includes cords, case, cover, and batteries.	Initial ear molds included in global rate. This code is for follow-up after first twelve months.
V5274	Assistive Listening Device	P	Same hearing loss criteria as V5242 above. Device available for recipients who are not capable of making adjustments to a hearing aid and would therefore be better suited with a listening device. For example, a nursing home resident may benefit as well from a bedside Assistive Listening Device than the smaller hearing aid which is difficult to adjust. The audiologist should be cognizant of this issue and make an appropriate prescription.	This is not an fm or rf system.
* **92541**	Spontaneous nystagmus test			
92542	Positional nystagmus test, minimum four positions			
92585	Auditory evoked potentials for evoked response audiometry and/or testing of central nervous system, comprehensive			
V5014	Repair/modification of a hearing aid			Submit itemized invoice. Includes time, handling, and parts.
Y0361	Repair charge, per hour charge		Over $15.00. Submit invoice.	
Y0366	Repair parts, hearing aids		Parts must be itemized on the invoice, and invoice attached to the claim.	Itemized parts required on claim.
Y0369	Repairs completed by manufacturer of hearing aid		Attach manufacturer's invoice to claim.	One per claim. Manual review of claim.
Y0370	Evaluation and service charge for hearing aid sent to manufacturer for repairs		Service charge.	One per claim.
Y0372	Hearing aid repair under $15.00		Minor repairs under $15.00	

This page reserved for future use.

INDEX